New Jersey Office of the Attorney General
Division of Consumer Affairs
State Board of Medical Examiners
Physician Assistant Advisory Committee
124 Halsey Street, 6th Floor, P.O. Box 45035
Newark, New Jersey 07101
(973) 504-6580

Physician Assistant Application for Licensure Checklist

Please complete and return with your application.

Applicant's name:_____

I. Application

A. Answer each question completely.

B. Be sure to have the application notarized.

C. Attach one (1) passport photograph (2" x 2") to the application.

D. Provide a valid daytime telephone number (include area code).

E. Attach additional documents (if applicable). (For example, to explain gaps in C.V. history, a statement of medical activity, or other.)

List here:

_____

_____

F. Provide a notarized copy of your birth certificate, passport or citizenship documents.

G. Provide name-change documentation (a notarized copy of the marriage license/court orders (if applicable)).

II. Verification forms (For any form which is not applicable, please print your name on it, indicate "N/A" and return it with the application.)

a. Military Service Profile (PA-94-ll-A) ☐ Yes ☐ N/A

b. P.A. License(s)/Registration (PA-94-ll-B) ☐ Yes ☐ N/A

c. N.C.C.P.A. Verfication (PA-94-ll-C) ☐ Yes

d. Certification of Good Standing (PA-94-ll-D) ☐ Yes ☐ N/A

e. Malpractice Certification (PA-94-ll-E ☐ Yes ☐ N/A

f. Verification of Graduation from a Physician Assistant Program (with one (1) passport photograph (2" x 2") (PA-94-ll-F) attached).

g. Employer(s) Verification of Nonmedical Employment (PA-94-ll-G)

h. Employer(s) Verification of Hospital/Medical Employment, Privileges or Appointment (PA-94-ll-H)

Checklist

III. Transcripts: Verification of Education

A. Physician Assistant Program

B. Transcripts from all colleges and universities attended

IV. Non-United States Accredited Credentials ☐ N/A

A. Evaluated High School Transcript/G.E.D. Verification

B. Notarized copies of diploma(s), sealed transcript(s) and evaluations

C. Licenses (Non-United States medical graduates only)

V. Curriculum Vitae

VI. Affidavit of Good Moral Character and Ethical Professional Activity (Notarized) (PA-94-VI)

VII. Application Fee

Personal check or money order payable to the Physician Assistant Advisory Committee, in the amount of $125.00. (This fee is not refundable.)

VIII. Certification and Authorization Form for a Criminal History Background Check.

IX. For any form which is not applicable, please print your name on it, indicate "N/A" and return it with the application.

Return this checklist with the application to:

State Board of Medical Examiners

Physician Assistant Advisory Committee

124 Halsey Sreet, 6th Floor

Newark, NJ 07101

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Dear Applicant:

Enclosed please find a New Jersey application for licensure. Please be advised that pursuant to **N.J.S.A**. **45:9-27.13 "The Physician Assistant Licensing Act"** provides for licensure of applicants who have met the following criteria.

1. The applicant is at least 18 years of age.
2. The applicant is of good moral character.
3. The applicant has successfully completed an approved program, meaning the applicant is a graduate of a Physician Assistant Program that has been approved by the Committee on Allied Health Education and Accreditation, or its successor, and
4. The applicant has passed the national certifying examination administered by the National Commission on Certification of Physician Assistants, or its successor.

Currently, there are no provisions for the licensure of ***non-United States accredited medical graduates*** as Physician Assistants who have not met the requirements outlined above.

In order for your application to be processed, you must adhere to the following guidelines in conjunction with the checklist provided. The return of your **checklist** to the Physician Assistant Advisory Committee will facilitate a timely review. Failure to answer each question completely will result in your application being returned to you for a response.

Very Important

Please read the application form in its entirety **before** completing. **Note: Under the Medical Conditions section of the application, there are instances when "not applicable" may apply.**

I. Application - Under question twelve (12), list the National Commission on Certification of Physician Assistants (N.C.C.P.A.) number. Also, list every license or certificate you hold as well as the number on that document, the state or jurisdiction that issued the license or certificate and the date of issuance and expiration.

A nonrefundable application fee of $125.00 is payable by check or money order at the time the application is submitted. ***Please make the check or money order payable to the Physician Assistant Advisory Committee***.

Please Note: For any form which is not applicable, ***print your name and write "not applicable"*** on the form and return it to the above address.

All required explanations and statements must be noted as such by either an explanation in the space provided or an attached explanation. Please mark all attached explanations with the word "**attachment"** and indicate on the attachment the corresponding page and question number.

You will need ***two (2) passport-size photographs (2" x 2")*** taken within the last ***six (6) months***. Please attach one photograph to page one (1) of the application. **(Reserve one (1) photograph for the Verification of Graduation from a Physician Assistant Program form PA-94-II-F).**

If you were born in the **United States**, you must submit **a notarized copy of your birth certificate**. If you were **born in another country** you must submit a notarized copy of your passport. **(Include the pages that reflect your name and date of birth.) Also, include a notarized copy of your Permanent Resident Card or Certificate of Naturalization/Citizenship.**

Be sure to indicate any other name by which you may be known so that the verifications and transcripts, which are essential to your application, are properly filed. You must provide a **notarized copy of your marriage certificate, divorce decree or court order** to validate any name change.

The application must be completed and notarized before submission. Be sure to make a copy of the checklist for your records and return the completed original to the Physician Assistant Advisory Committee.

II. Verification Forms A-H (These forms may be duplicated if necessary.)

The issuing authority, state or employer must return the applicable form directly to the Physician Assistant Advisory Committee at the address listed on the form. ***Forms submitted to the Physician Assistant Advisory Committee by an applicant will not be accepted.***

A. Military Service Profile (PA-94-II-A)

Forward a copy of this form to every branch of the U.S. military service in which you have served. The military branch(es) should be advised that profiles that are incomplete will not be accepted.

B. Certification of Physician Assistant License/Registration/Permit Issued (PA-94-II-B)

Forward a copy of this form to each State where you were licensed or are currently licensed as a physician assistant.

C. N.C.C.P.A. Certification (PA-94-II-C) Registration for Exam or Verification of Certification

The form must be sent to the **National Commission on Certification of Physician Assistants (N.C.C.P.A.), 12000 Findley Road, Suite 200, Duluth, GA 30097**, so that the Commission can independently verify that you have been registered to sit for the examination, **or** that you have taken the exam and been certified. If you passed the exam and have been certified, you should request that the Commission forward verification of that certification, and the scores you achieved on the exam, directly to the Physician Assistant Advisory Committee.

D. Certification of Good Standing (PA-94-II-D)

Forward a copy of this form to each state/country where you are currently, or have been in the past, licensed/certified as a health care professional other than a physician assistant. For example, as a physician, nurse, paramedic, X-ray technician, respiratory therapist, E.M.T., etc.

E. Malpractice Certification (PA-94-II-E)

Forward a copy of this form to every malpractice insurance carrier which has provided coverage to you during the ***five (5) year period*** that immediately precedes the submission of your application for licensure in New Jersey. If your malpractice coverage is provided by a hospital, forward this form to the risk management office of the hospital. If your malpractice insurance is provided by a physician in private practice, please forward this form to the physician/supervising physician. If you are self-

insured, provide the form to your carrier. ***The carrier should be directed to return this form directly to the Physician Assistant Advisory Committee along with a letterhead and/or business card, at the address listed on the top of page one of this checklist. The malpractice certification form must be mailed directly by the carrier or facility and must not be mailed by the applicant.***

F. Verification of Graduation from a Physician Assistant Program (PA-94-II-F)

Please attach a passport-size **photograph (2" x 2")** taken within the past ***six (6) months***. Please forward this form to your Physician Assistant Program to verify your graduation. This form must be mailed directly to the Physician Assistant Advisory Committee.

G. Verification of Nonmedical Employment (PA-94-I-G)

Forward a copy of this form to every nonmedical facility for whom you have worked in a nonmedical capacity within the past ***five (5) year period*** that immediately precedes the submission of your application for licensure in New Jersey.

Please ensure that your employer understands that this form must be completed in its entirety, and then sent to the Committee along with a letterhead and/or business card. Incomplete verification forms will not be accepted. Please Note: This form must be mailed by the employer and must not be submitted by the applicant.

H. Verification of Medical Employment Form (PA-94-II-H)

Forward a copy of this form to every medical facility or hospital/medical employer for whom you have worked in a medical capacity within the past ***five (5) year period*** that immediately precedes the submission of your application for licensure in New Jersey.

Please ensure that your employer understands that this form must be completed in its entirety, and then sent to the Committee along with a letterhead and/or business card. Incomplete verification forms will not be accepted. Please Note: This form must be mailed by the employer and must not be submitted by the applicant.

III. Verification of Education

All applicants must request official transcripts from all institutions attended to the present. The transcripts must be mailed directly from the schools and one must be the final transcript from the Physician Assistant Program. ***Transcripts submitted to the Physician Assistant Advisory Committee by the applicant will not be accepted.***

Please Note: If you attended high school in the United States, a high school transcript is not required.

However, ***all applicants who attended high school outside of the United States are required to submit a high school transcript and all other transcripts which must be evaluated by World Education Services, Inc.*****, P.O. Box 745, Old Chelsea Station, New York, NY 10113-0745. Telephone: 1-800-937-3895.**

IV. A. Foreign Credentials (which are not in English)

Graduates of foreign schools must also submit a notarized copy(ies) of their original diploma(s) and an English translation. Only translations by official agencies recognized by the State Board of Medical Examiners are acceptable and are listed below:

- Allen Translation Service - Box 1529, Morristown, NJ 07860. Telephone: (973) 292-2737

- The Language Center, Inc. - 144 Tices Languages, East Brunswick, NJ
  Telephone: (732) 613-4554 and (212) 854-4888.

- Continental Translation Service - 6 East 43rd Street, New York, NY 10017.
  Telephone: (212) 867-3646.

- Columbia University City of New York Tutoring and Translation Agency, Lewishon, New York, NY. Telephone: (212)854-4888.

- Language Matters - 10 West 37th Street, New York, NY. Telephone: (212) 594-8214.

- Action Translation Bureau - 187 Tilden Drive, East Hanover, NJ 07936.
  Telephone: (973) 887-3580.

- Garden State Translation, Inc. 484 Bloomfield Avenue, Suite 9, Montclair, NJ.
  Telephone: 1-800-924-3659.

- Berlitz School of Languages - Every Berlitz School is accepted.

- Translation Service Company of America, Inc. 10 West 37th Street, New York, New York.

- Interworld Translation Service, Inc. - 10 West 37th Street, New York, NY

- Translation Company of New York, Inc. - 8 South Maple Avenue, Marlton, NJ 08053.

- Inlingua School of Language/Translation Service - 95 Summit Avenue, Summit, NJ 07901 and 171 East Ridgewood Avenue, Ridgewood, NJ 07450.

Please Note: The above agencies are translation agencies not evaluation agencies. All foreign transcripts must be evaluated by World Education Services. **(See information under Verification of Education.)**

Foreign Nationals who are licensed to practice in the medical profession in the country in which their education was received, must submit a notarized copy of their license and an approved translation of the same.

V. Curriculum Vitae/Resume

Note: List all activities chronologically, including formal education, professional experiences/employment and activities. Also, include a rationale for any gaps in your employment or education. **Begin with high school and follow through to the present date, specifying the beginning and ending months and years of education attendance and employment.** Be sure to provide addresses and phone numbers for all employers. ***Please submit a written explanation for any and all education and employment gaps.***

VI. Affidavit of Good Moral Character

The Affidavit of Good Moral Character and Professional Activity must be completed, signed by the applicant and notarized before submission of the application. If you have answered yes to number ***twelve (12)*** on the Affidavit of Good Moral Character, the following documentation is required: (a) A description of the clinical aspects for each incident as it would be explained to a fellow professional; (b) for each incident you must submit a copy of the original complaint or a copy of the Bill of Particulars; for each closed malpractice suit, you must submit a copy of the Final Order or settlement that rendered a final disposition.

VII. Fees

Please forward a **check or money order in the amount of $125.00** with your application. If approved for licensure, you will be notified to forward the licensure fee of **$220.00 for a permanent license or $50.00 for a temporary limited license**, whichever is applicable.

VIII. Certification and Authorization Form for a Criminal Background Check

Complete this form in its entirety and mail it to the address on top of page one of this checklist. **Please do not send any fees** when returning the Certification and Authorization Form. Upon receipt of the Certification and Authorization Form, a Sagem Morpho letter will be sent to each applicant with instructions regarding how to proceed to have the fingerprint process completed.

If you answered **"Yes"** to question **six (6),** please submit a written explanation to the Physician Assistant Advisory Committee. Also, contact the court involved and have the court forward a copy of the Indictment, the Judgment of Conviction and the Transcript of Sentencing to the address on top of page one of this checklist.

IX. Expected Time Frame

Please be advised that typically, the licensure approval process takes ***twelve (12) to fifteen (15) weeks***.

If you have any questions or need assistance, contact the Physician Assistant Advisory Committee at **(973) 504-6580**.

Attach a clear, full-face passport-style photograph (2″x 2″) of your head and shoulders, taken within the past six months.

A photo is required with each application.

Do not use staples to attach the photo.

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Physician Assistant Application for Licensure

Date : _____

A nonrefundable application filing fee of $125.00, in the form of a check or money order made out to the State of New Jersey, must be submitted with this application. (Applicants should understand that if the application filing fee is paid with a personal check, and the check is returned by the bank due to insufficient funds, the next step in the licensure or certification process will be delayed until the fee is paid.)

The Committee maintains, as part of its responsibilities, a record of your home address, business address and mailing address. You may choose which of these addresses will be considered as your "address of record." If you do not indicate (by putting a check in the appropriate box) which address should be used as your address of record, your mailing address will be considered to be your address of record. A post office box may be used as your address of record, but only if you provide another address which includes a street, city, state and ZIP code.

Information that you provide on this application may be subject to public disclosure as required by the Open Public Records Act (OPRA).

Please print clearly. You must answer all of the questions on this application.

Personal Information

Date of birth: _____
Month Day Year

Place of birth: _____
City State Country

1. Name ☐ Mr. ☐ Mrs. ☐ Ms. _____ (_____)
Last name First name Middle initial Maiden name

2. Address

☐ Home: _____
Street or P.O. Box City State ZIP code County

_____ _____
Telephone number (include area code) E-mail address

☐ Business: _____
Name of company Telephone number (include area code)

_____
Street City State ZIP code County

☐ Mailing: _____
Street or P.O. Box City State ZIP code County

3. Social Security Number

You **must** provide your Social Security number to the Board or Committee. Failure to do so will result in denial/nonrenewal of licensure or certification.

*Social Security Number: _____ -_____ - _____

*Pursuant to N.J.S.A. 54:50-24 et seq. of the New Jersey taxation law, N.J.S.A. 2A:17-56.44e of the New Jersey Child Support Enforcement Law, Section 1128E(b)(2)A of the Social Security Act and 45 C.F.R. 60.7,60.8 and 60.9, the Board or Committee is required to obtain your Social Security number. Pursuant to these authorities, the Board or Committee is also obligated to provide your Social Security number to:

a. the Director of Taxation to assist in the administration and enforcement of any tax law, including for the purpose of reviewing compliance with State tax law and updating and correcting tax records;

b. the Probation Division or any other agency responsible for child support enforcement, upon request; and

c. the National Practitioner Data Bank and the H.I.P. Data Bank, when reporting adverse actions relating to health care professionals.

4. Citizenship / Immigration Status

Federal law limits the issuance or renewal of professional or occupational licenses or certificates to U.S. citizens or qualified aliens. To comply with this federal law, check the appropriate box below which indicates your citizenship/immigration status. If you are not a U.S. citizen, attach a copy of your alien registration card (front and back) or other documentation issued by the office of U.S. Citizenship and Immigration Services (USCIS).

☐ U.S. citizen
☐ Alien lawfully admitted for permanent residence in U.S.
☐ Other immigration status

Questions about your immigration status and whether or not it is a qualifying status under federal law should be directed to the USCIS at: 1-800-375-5283.

5. Student Loan

Are you in default in regard to any student loan obligation(s)? ☐ Yes ☐ No

If "Yes," you must obtain documentary evidence that you have reached an arrangement with the bank or with the entity that issued your student loan, for the eventual repayment of the loan. You will not be able to obtain a license or certificate unless you provide the required documents concerning the plan for payment of your student loan.

6. Child Support

Please certify, under penalty of perjury, the following:

a. Do you currently have a child-support obligation? ☐ Yes ☐ No

(1) If "Yes," are you in arrears in payment of said obligation? ☐ Yes ☐ No

(2) If "Yes," does the arrearage match or exceed the total amount payable for the past six months? ☐ Yes ☐ No

b. Have you failed to provide any court-ordered health insurance coverage during the past six months? ☐ Yes ☐ No

c. Have you failed to respond to a subpoena relating to either a paternity or child-support proceeding? ☐ Yes ☐ No

d. Are you the subject of a child-support-related arrest warrant? ☐ Yes ☐ No

In accordance with N.J.S.A. 2A:17-56.44d, an answer of "Yes" to any of the questions a(1) through d will result in a denial of licensure or certification. Furthermore, any false certification of the above may subject you to a penalty, including, but not limited to, immediate revocation or suspension of licensure or certification.

_____ _____ _____

Applicant's name (please print) Applicant's signature Date

7. Medical Conditions Questions

Questions a through f pertain to medical conditions and use of chemical substances. Please read the definitions carefully. Your responses will be treated confidentially and retained separately. Please be aware that you have the right to elect not to answer those portions of the following questions which inquire as to the illegal use of controlled dangerous substances or activity if you have reasonable cause to believe that answering may expose you to the possibility of criminal prosecution. In that event, you may assert the Fifth Amendment privilege against self-incrimination. Any claim of Fifth Amendment privilege must be made in good faith. If you choose to assert the Fifth Amendment, you must do so in writing. You must fully respond to all other questions on the application. Your application for licensure or certification will be processed if you claim the Fifth Amendment privilege against self-incrimination. You should be aware, however, that you may later be directed by the Attorney General to answer a question that you have refused to answer on the basis of the Fifth Amendment, provided that the Attorney General first grants you immunity afforded by statutory law. (N.J.S.A. 45:1-20.)

"Ability to practice as a physician assistant" is to be construed to include all of the following:

a. The cognitive capacity to exercise the reasonable judgments of a physician assistant, and to learn and keep abreast of professional developments; and

b. The ability to communicate those judgments and related information to patients and other interested parties, with or without the use of aids or devices, such as voice amplifiers; and

c. The physical capability to perform the duties of a physician assistant, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, H.I.V. disease, tuberculosis, drug addiction and alcoholism.

"Chemical substance" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, or within the previous two years.

"Illegal use of controlled dangerous substance" means the use of a controlled dangerous substance obtained illegally (e.g. heroin or cocaine) as well as the use of controlled dangerous substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

a. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? ☐ Yes ☐ No

b. Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program**?
☐ Yes ☐ No ☐ Not applicable

c. Are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting or manner in which you have chosen to practice? ☐ Yes ☐ No ☐ Not applicable

d. Does your use of chemical substance(s) in any way impair or limit your ability to practice your profession with reasonable skill and safety? ☐ Yes ☐ No ☐ Not applicable

e. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?
☐ Yes ☐ No

f. Are you currently engaged in the illegal use of controlled dangerous substances? (Recall that "currently" is defined as "within the last two years.") ☐ Yes ☐ No

If you answered "Yes" to question f, are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? ☐ Yes ☐ No

** If you receive such ongoing treatment or participate in such a monitoring program, the Committee will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition so as to determine whether an unrestricted license or certificate should be issued, whether conditions should be imposed or whether you are not eligible for licensure or certification.

_____ _____

Signature of applicant Date

8. Have you ever been summoned; arrested; taken into custody; indicted; tried; charged with; admitted into pre-trial intervention (P.T.I.); or pled guilty to any violation of law, ordinance, felony, misdemeanor or disorderly persons offense, in New Jersey, any other state, the District of Columbia or in any other jurisdiction? (Parking or speeding violations need not be disclosed, but motor vehicle violations such as driving while impaired or intoxicated must be.) ☐ Yes ☐ No

9. Have you ever been convicted of any crime or offense under any circumstances? This includes, but is not limited to, a plea of guilty, non vult, nolo contendere, no contest, or a finding of guilt by a judge or jury. ☐ Yes ☐ No

   If "Yes," provide a copy of the judgment of conviction and the release from parole or probation. Please provide a complete explanation. (Attach additional sheets of paper to this application.)

10. Have you ever served in the Armed Forces of the United States? ☐ Yes ☐ No

    If "Yes," submit a copy of your military discharge documents and see the instructions on the Committee's Military Service Profile form (PA9411-A).

11. Have you previously applied for a license or certificate as a physician assistant in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No
    If "Yes," when and where? _____

12. Do you currently hold, or have you ever held, a professional license or certificate of **any** kind in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

    If "Yes," for each license or certificate held, provide the date(s) held and the number(s). If the license or certificate was issued under a different name, please provide that name. _____
    Last name First name Middle initial

Type of license or certificate	Number	State or jurisdiction that issued the license or certificate	Date issued/expired

    (If you hold a certificate issued by the National Commission on Certification of Physician Assistants (N.C.C.P.A.), you must contact the Commission to request that documentation confirming your acquisition of the certificate be forwarded directly to the Committee.)

13. Have you ever been disciplined or denied a license or certificate as a physician assistant or any other professional license in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

14. Have you ever had a professional license or certificate of any type suspended, revoked or surrendered in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

15. Has any action (including the assessment of fines or other penalties) ever been taken against your professional practice by any agency or certification board in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

16. Have you ever been named as a defendant in any litigation related to practice as a physician assistant or any other professional practice in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

17. Are you aware of any investigation pending against a professional license or certificate issued to you by any professional board in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

18. Are there any criminal charges now pending against you in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

19. Have you ever been sanctioned by, or is any action pending before, any employer, association, society, or other professional group related to practice as a physician assistant or any other professional practice in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

    If the answer to any of the above questions, numbers 13 through 19, is "Yes," provide a complete explanation of the circumstances leading to the action, and any supporting documentation, on separate sheets of paper.

Education

1. What is the name and address of the high school(s) you attended? _____
   Name of high school

   _____
   Street address City State ZIP code

2. What years did you attend high school? _____

3. If you attended high school or secondary school outside the United States, please submit a transcript and/or diploma (and an evaluation if necessary).

4. What is the name and address of every college or university, and the name and address of the Physician Assistant Program, that you attended? (List every college and university that you have ever attended, starting with the most recent.)

   _____
   Name of college or university Dates attended (from/to)

   _____
   Street address City State ZIP code

   _____
   Name of college or university Dates attended (from/to)

   _____
   Street address City State ZIP code

   _____
   Name of college or university Dates attended (from/to)

   _____
   Street address City State ZIP code

5. A) List all degrees from recognized colleges or universities. ***It is your responsibility to have the colleges or universities forward to the Committee the official transcripts of all degrees.***

College or University	Inclusive years	Degree, Diploma or Certificate	Date granted

A curriculum vitae is required. Label all gaps in chronological order and provide a rationale for each gap.

Employment History

Describe **all employment**. List your current employer first. (Please explain any gaps in your employment history.) Use additional sheets of paper if necessary.

a.

Name of facility | Street address

City | State | ZIP code | Telephone number (include area code)

Name of supervisor or supervising physician | Supervisor's title | Applicant's title

Dates of employment: from _____ (Month/Year) to _____ (Month/Year)

Description of job functions, responsibilities and the reason for leaving:

b.

Name of facility | Street address

City | State | ZIP code | Telephone number (include area code)

Name of supervisor or supervising physician | Supervisor's title | Applicant's title

Dates of employment: from _____ (Month/Year) to _____ (Month/Year)

Description of job functions, responsibilities and the reason for leaving:

c.

Name of facility | Street address

City | State | ZIP code | Telephone number (include area code)

Name of supervisor or supervising physician | Supervisor's title | Applicant's title

Dates of employment: from _____ (Month/Year) to _____ (Month/Year)

Description of job functions, responsibilities and the reason for leaving:

Professional References

Please provide the name, address and other requested information of at least two people who are familiar with your work experience. (Note: You may not use any member of your family as a professional reference.)

1.

Name _____ Street address _____

City _____ State _____ ZIP code _____ Telephone number day (include area code) _____

Telephone number evening (include area code) _____ Profession _____ Title _____

License number (If applicable) _____

2.

Name _____ Street address _____

City _____ State _____ ZIP code _____ Telephone number day (include area code) _____

Telephone number evening (include area code) _____ Profession _____ Title _____

License number (If applicable) _____

AFFIDAVIT

This affidavit is to be executed by the applicant before a notary public:

State of: _____

County of: _____ } ss.

I, _____ , in making this application to the Physician Assistant Advisory Committee for licensure or certification under the provisions of Title 45 of the General Statutes of New Jersey and the Rules of the Physician Assistant Advisory Committee, swear (or affirm) that I am the applicant and that all information provided in connection with this application is true to the best of my knowledge and belief. I understand that any omissions, inaccuracies or failure to make full disclosures may be deemed sufficient to deny licensure or certification or to withhold renewal of or suspend or revoke a license or certificate issued by the Committee.

I further swear (or affirm) that I have read N.J.S.A. 45:9-27.10 et seq., together with the Rules and Regulations of the Physician Assistant Advisory Committee, N.J.A.C. 13:35-2B.1 et seq., and fully understand that in receiving licensure or certification from the Committee, I bind myself to be governed by them.

Furthermore, I voluntarily consent to a thorough investigation of my present and past employment and other activities for the purpose of verifying my qualifications for licensure or certification. I further authorize all institutions, employers, agencies and all governmental agencies and instrumentalities (local, state, federal or foreign) to release any information, files or records requested by the Committee.

_____
Signature of applicant

Sworn and subscribed to before me this _____

day of _____ , _____
Month Year

_____
Name of Notary Public (please print)

_____
Signature of Notary Public

Affix Seal Here

Official Use Only
☐ Dual License
License Type 1
_____
Applicant's Number
_____
License Type 2
_____
Applicant's Number
_____

New Jersey Office of the Attorney General
Division of Consumer Affairs
State Board of Medical Examiners
Physician Assistant Advisory Committee
P.O. Box 45035
Newark, New Jersey 07101
(973) 504-6580

Official Use Only
☐ Resubmit
_____
Board or Committee
_____

Certification and Authorization Form For a Criminal History Background Check

Directions: Answer all of the questions on this form.

1. Name ☐ Mr. ☐ Mrs. ☐ Ms. _____ (_____)
   Last First Middle Maiden Name

2. Address _____
   Street or P.O. Box City State ZIP code

3. Date of birth __ __ /__ __ /__ __ Sex: ☐ Male ☐ Female
   Month Day Year

4. Social Security number _____/_____ / _____

5. Have you completed the fingerprinting process for any **Board or Committee of the New Jersey Division of Consumer Affairs** since November 2003? ☐ Yes ☐ No
   If "No," you will receive a separate mailing from the Board or Committee regarding the criminal history background process. Please send no payment now.
   If "Yes," please provide the following information and follow the instructions outlined below:

   _____ _____
   Board or committee requiring the fingerprinting Month and year you were fingerprinted

   If you were fingerprinted after November 2003 as part of the criminal history background process for licensure or certification by any other any other **Board or Committee of the New Jersey Division of Consumer Affairs** (a background check conducted for the Department of Education, another state agency or another state does not apply) you will not be required to be fingerprinted a second time. However, the Division must perform a criminal history background check each time you apply for licensure or certification. **The fee for this service is $25.30.** Payment should be made in the form of a check or money order payable to the State of New Jersey and should accompany your application packet.

6. Have you ever been arrested and/or convicted of a crime or offense? (Minor traffic offenses such as a parking or speeding violations need not be listed.) ☐ Yes ☐ No

   Every such conviction on record must be disclosed. A true copy of every police report, judgment of conviction, sentencing order and termination of probation order, if applicable, **must** be submitted with this form. Any documents (including employer or supervisor letters of reference, if applicable) which present clear and convincing evidence of rehabilitation **must** be submitted with this form. **Failure to follow these instructions may result in the denial of an initial application.**

   Note: Copies of judgments, sentencing and termination of probation orders may be obtained from the clerk of the county where those orders, disposing of the conviction, were issued and filed.

   Your continuing responsibility to disclose convictions of crimes or offenses: You **must** notify the Board or Committee within five (5) business days if you are convicted of any crimes or offenses after this form has been completed.

Continuation on the reverse side ➡

CERTIFICATION

I, _____, in making this application to the Board or Committee for certification or licensure, certify that I am the applicant and that all of the information provided in connection with this application is true to the best of my knowledge and belief. I understand that any omissions, inaccuracies or failure to make full disclosures may be deemed sufficient to deny certification or licensure or to withhold renewal of or suspend or revoke a certificate or license issued by the Board or Committee.

I voluntarily consent to a thorough investigation of my present and past employment and other activities for the purpose of verifying my qualifications for certification or licensure. I further authorize all institutions, employers, agencies and all governmental agencies and instrumentalities (local, state, federal or foreign) to release any information, files or records requested by the Board or Committee.

I certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

_____ _____

Signature of applicant Date

New Jersey Office of the Attorney General
Division of Consumer Affairs
State Board of Medical Examiners
Physician Assistant Advisory Committee
124 Halsey Street, 6th Floor, P.O. Box 45035
Newark, New Jersey 07101
(973) 504-6580

Military Service Profile

Applicant's name:_____

Applicant's rank :_____

Branch of service:_____

1. What position and rank does this individual hold or did he/she hold when discharged?

   _____

   _____

2. What were this individual's dates of service?_____

3. What type of discharge did this individual receive?_____

   a. What was the date of discharge?_____

4. Was the individual on probation, suspended or in any way sanctioned/disciplined while in the military? ☐ Yes ☐ No

5. Was this individual granted a leave of absence while in the military? ☐ Yes ☐ No

6. Were any restrictions placed on this individual's activities which were not placed on all other personnel holding similar positions? ☐ Yes ☐ No

7. Would this individual be recommended for re-enlistment? ☐ Yes ☐ No

   If "No," please explain._____

   _____

8. Would this individual be recommended for promotion? ☐ Yes ☐ No

   If "No," please explain._____

   _____

9. Did quality assessment review of this individual ever result in a negative finding? ☐ Yes ☐ No

   If "Yes," please explain._____

   _____

10. Was this individual in the Medical Corps? ☐ Yes ☐ No

If "Yes," please answer questions A-H:

A. Was this individual denied clinical privileges while in the military? ☐ Yes ☐ No

B. Were any restrictions placed on this individual's clinical privileges? ☐ Yes ☐ No

C. Were any formal patient or staff complaints filed against this individual? ☐ Yes ☐ No

D. Were any incident reports filed involving the professional conduct or behavior of this individual? ☐ Yes ☐ No

E. Was this individual ever subject to nonroutine monitoring while in the military service? ☐ Yes ☐ No

F. Was this individual removed from a call schedule for cause? ☐ Yes ☐ No

G. Was this individual subject to nonroutine quality assessment review? ☐ Yes ☐ No

H. Would you recommend this individual for privileges at a hospital? ☐ Yes ☐ No

Please supply any additional comments or information that the Committee should consider prior to determining this applicant's eligibility for licensure.

_____

_____

Please print the name of the individual supplying the information: _____

Signature of the individual supplying the information: _____

Address and full telephone number where the individual supplying the information may be contacted:

_____

_____

_____

Date form was completed: _____

Please return directly to:

State Board of Medical Examiners
Physician Assistant Advisory Committee
124 Halsey Street - 6th floor
P. O. Box 45035
Newark, NJ 07101

Please Affix Official Seal Here

New Jersey Office of the Attorney General
Division of Consumer Affairs
State Board of Medical Examiners
Physician Assistant Advisory Committee
124 Halsey Street, 6th Floor, P.O. Box 45035
Newark, New Jersey 07101
(973) 504-6580

Certification of Physician Assistant License/Registration/Permit Issued

Please complete the top portion only and forward one form to each state where you hold or have held a license to practice as a Physician Assistant. Extra copies may be photocopied if needed.

This section is to be completed by the applicant:

I,_____, am applying for a New Jersey Physician Assistant License.

The New Jersey Physician Assistant Advisory Committee requests that I submit evidence that my License/Registration

in the State of _____is in good standing.

I was granted License/Registration Number_____on _____.
Date

You are hereby authorized to release any information in your files, favorable or otherwise, directly to the **New Jersey Physician Assistant Advisory Committee, 124 Halsey Street, P.O. Box 45035, Newark, New Jersey 07101**. Your early attention is appreciated.

_____
Applicant's signature

This section is to be completed by an Official of the Issuing Authority:

Please complete and return this form to: **Dept. of Law & Public Safety, Division of Consumer Affairs, Physician Assistant Advisory Committee, P.O. Box 45035, Newark, New Jersey 07101**.

Name:_____

License/registration number :_____ Date issued: _____ Expiration date: _____

Is license/registration current? ☐ Yes ☐ No

If "No," please explain: _____

_____

Is license/registration in good standing? ☐ Yes ☐ No

If "No," please explain:_____

_____

Additional information or other remarks:_____

_____ _____ _____
Date Print name Signature

_____ _____
State Board Title

(Seal of attesting Issuing Authority must be impressed over signature.)

PA-94-ll-B

New Jersey Office of the Attorney General
Division of Consumer Affairs
State Board of Medical Examiners
Physician Assistant Advisory Committee
124 Halsey Street, 6th Floor, P.O. Box 45035
Newark, New Jersey 07101
(973) 504-6580

Score Release Form

National Commission on Certification of Physician Assistants
Certification Verification Request

Section I Instructions to Applicant

For the Committee to obtain verification of your N.C.C.P.A. credentials, complete the following information, sign, date and send this form to the N.C.C.P.A., 12000 Findley Road, Suite #200 Duluth, GA. 30097.

Section II Personal Information and Signature

Print your name as it appears on your Certificate and your address.

_____

Last name | First name | Middle initial | Former name

_____

Address | Apt. number

_____

City | State | ZIP code

☐ Registered to take exam on: Date: _____

☐ Completed exam on: Date: _____

Certificate number: _____ Expiration date:_____

I hereby give my permission to the N.C.C.P.A. to verify my credentials to the New Jersey Physician Assistant Advisory Committee pursuant to N.J.S.A. 45:9-27.13 et seq.

_____ _____

Signature | Date

New Jersey Office of the Attorney General
Division of Consumer Affairs
State Board of Medical Examiners
Physician Assistant Advisory Committee
124 Halsey Street, 6th Floor, P.O. Box 45035
Newark, New Jersey 07101
(973) 504-6580

Certification of Good Standing Non-Physician Assistant License/Registration/Permit Issued/Certification

Please complete the top portion only and forward one form to each state where you hold or have held a state issued license, permit or certificate as a health care provider other than a physician assistant. Extra copies may be photocopied if needed.

This section is to be completed by the applicant:

I,_____ am applying for a New Jersey Physician Assistant License.

The New Jersey Physician Assistant Advisory Committee requests that I submit evidence that my License/Registration

in the State of _____is in good standing.

I was granted License/Registration Number_____on _____ .
Date

You are hereby authorized to release any information in your files, favorable or otherwise, directly to the **New Jersey Physician Assistant Advisory Committee, 124 Halsey Street, P.O. Box 45035, Newark, New Jersey 07101**. Your early attention is appreciated.

_____
Applicant's signature

This section is to be completed by an Official of the Issuing Authority:

Please complete and return this form to: **Dept. of Law & Public Safety, Division of Consumer Affairs, Physician Assistant Advisory Committee, P.O. Box 45035, Newark, New Jersey 07101**.

Name:_____

License/registration number :_____ Date issued: _____ Expiration date: _____

Is license/registration current? ☐ Yes ☐ No

If "No," please explain: _____

_____

Is license/registration in good standing? ☐ Yes ☐ No

If "No," please explain:_____

_____

Additional information or other remarks:_____

_____ _____ _____
Date Print name Signature

_____ _____
State Board Title

PA-94-ll-D

(Seal of attesting Issuing Authority must be impressed over signature.)

New Jersey Office of the Attorney General
Division of Consumer Affairs
State Board of Medical Examiners
Physician Assistant Advisory Committee
124 Halsey Street, 6th Floor, P.O. Box 45035
Newark, New Jersey 07101
(973) 504-6580

Malpractice Certification Form

Name of applicant:_____

Name of employer:_____

Name of malpractice carrier: _____

Address of malpractice carrier: _____

_____

Dates of coverage: from _____ to _____

Names and status of each case in which this applicant was involved:

Plaintiff's Name:	**Status:**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

1. Was this medical practitioner ever denied malpractice coverage? ☐ Yes ☐ No
2. Was this medical practitioner's practice ever curtailed or limited? ☐ Yes ☐ No
3. Was this medical practitioner ever assessed a surcharge based upon specific claims history? ☐ Yes ☐ No
4. Was office monitoring or special hospital monitoring ever required for this medical practitioner? ☐ Yes ☐ No

Name and title of person completing this form:_____

Signature of person completing this form:_____

Date form was completed:_____

Please return directly to: **State Board of Medical Examiners**
Physician Assistant Advisory Committee
124 Halsey Street - 6th floor
P. O. Box 45035
Newark, NJ 07101

Please attach a letterhead or some form of identification such as a business card for the individual supplying this information.

New Jersey Office of the Attorney General
Division of Consumer Affairs
State Board of Medical Examiners
Physician Assistant Advisory Committee
124 Halsey Street, 6th Floor, P.O. Box 45035
Newark, New Jersey 07101
(973) 504-6580

Verification of Graduation from a Physician Assistant Program

Part 1 - Directions for applicant:
Complete the top of this page and send this form to the director of your Physician Assistant Program for completion of Part 2.

Attach Photo Here

Name:_____
Last First

Address:_____
Street City State ZIP code

Part 2 - Directions for Program Director:
Complete the bottom portion of this page and return it directly to the Physician Assistant Advisory Committee.

1. (a) Did the individual noted above attend your program? ☐ Yes ☐ No

   (b) Is the individual whose photograph is attached, the individual who attended this Physician Assistant Program? ☐ Yes ☐ No

2. What were the applicant's dates of enrollment in the program? From_____ to _____.

3. Did this individual complete all of the requirements of the Physician Assistant Program? ☐ Yes ☐ No

   If "No," please explain: _____

4. What was the date of graduation? _____

5. Did this individual take a leave of absence during his/her attendance at this Physician Assistant Program? ☐ Yes ☐ No

   If "Yes," please explain: _____

6. Was this individual on probation during his/her attendance at this Physician Assistant Program? ☐ Yes ☐ No

   If "Yes," please explain: _____

7. Was this individual ever disciplined or under investigation during his/her attendance at this Physician Assistant Program? ☐ Yes ☐ No

8. Were any negative reports filed by instructors regarding this individual? ☐ Yes ☐ No

9. Were any special requirements imposed on this individual that were not required of all other students at his/her level of education? ☐ Yes ☐ No

10. Please supply any additional comments or information that the Committee should consider prior to determining this applicant's eligibility for licensure.

I hereby certify that the person whose name is on this form successfully completed the Physician Assistant Program and that his/her scholastic standing and practical performance were satisfactory during the course of study completed.

Name of institution:_____

Address of institution:_____

_____

Name of the Director of the Program (please print): _____

Signature of the Director of the Program: _____ Date: _____

Please return directly to:

State Board of Medical Examiners
Physician Assistant Advisory Committee
124 Halsey Street - 6th floor
P. O. Box 45035
Newark, NJ 07101

Affix School Seal

New Jersey Office of the Attorney General
Division of Consumer Affairs
State Board of Medical Examiners
Physician Assistant Advisory Committee
124 Halsey Street, 6th Floor, P.O. Box 45035
Newark, New Jersey 07101
(973) 504-6580

Verification of Non-Medical Employment

Applicant's name:_____

Employer's name:_____

Employer's address:_____

Employer's telephone number (include area code): _____

1. What position did the above individual hold when employed by you? _____
2. What were his/her dates of employment? From: _____ to: _____.
3. Did he/she leave your employment in good standing? ☐ Yes ☐ No
4. Was the individual on probation, suspended or in any way sanctioned/disciplined while employed by you? ☐ Yes ☐ No
5. Was this individual granted a leave of absence while employed by you? ☐ Yes ☐ No
6. Were any restrictions placed on his/her activities which were not placed on all other employees holding similar positions? ☐ Yes ☐ No
7. Were any formal staff complaints ever filed against this individual? ☐ Yes ☐ No
8. Were any incident reports filed involving the professional conduct or behavior of this individual? ☐ Yes ☐ No
9. Was he/she ever subject to nonroutine monitoring while in your employment? ☐ Yes ☐ No
10. Was this individual subject to nonroutine quality assessment review? ☐ Yes ☐ No
11. Did quality assessment review of this individual ever result in a negative finding? ☐ Yes ☐ No
12. Were any actions filed naming this individual as a defendant based on his/her actions during his/her period of employment by you? ☐ Yes ☐ No
13. Would you consider rehiring this individual? ☐ Yes ☐ No

    If "No," please explain: _____

    _____

Please supply any additional comments or information that the Committee should consider prior to determining this applicant's eligibility for licensure.

_____

_____

Please print the name of person/employer supplying information:_____

Signature of person/employer supplying information: _____

Date form was completed: _____

Please attach a letterhead or some form of identification such as a business card for the individual supplying this information.

Please return directly to:

State Board of Medical Examiners
Physician Assistant Advisory Committee
124 Halsey Street - 6th floor
P. O. Box 45035
Newark, NJ 07101

PA-94-ll-G

New Jersey Office of the Attorney General
Division of Consumer Affairs
State Board of Medical Examiners
Physician Assistant Advisory Committee
124 Halsey Street, 6th Floor, P.O. Box 45035
Newark, New Jersey 07101
(973) 504-6580

Verification of Hospital/Medical Employment, Privileges or Appointment

Applicant's name:_____

Name of Hospital/Facility:_____

Hospital/Facility address:_____

Hospital/Facility's telephone number (include area code): _____

1. What position did this health practitioner hold at your facility? _____

2. What were this health practitioner's dates of employment at your facility?

   From: _____ to: _____.

3.	Was this health practitioner placed on probation, suspended or in any way sanctioned/disciplined while at your facility?	☐ Yes	☐ No
4.	Was this health practitioner granted a leave of absence while employed at your facility?	☐ Yes	☐ No
5.	Were any restrictions placed on this health practitioner's activities that were not placed on all other employees holding similar positions?	☐ Yes	☐ No
6.	Were any restrictions placed on this health practitioner's privileges?	☐ Yes	☐ No
7.	Were any formal patient or staff complaints filed against this health practitioner?	☐ Yes	☐ No
8.	Were any incident reports filed involving the professional conduct or behavior of this health practitioner?	☐ Yes	☐ No
9.	Was this health practitioner ever subject to nonroutine monitoring while at your facility?	☐ Yes	☐ No
10.	Was this health practitioner involuntarily removed from a call schedule for cause?	☐ Yes	☐ No
11.	Was this health practitioner subject to nonroutine quality assessment review?	☐ Yes	☐ No
12.	Was this health practitioner the subject of a negative review by a quality assurance or departmental committee?	☐ Yes	☐ No
13.	Was this health practitioner the subject of an investigation by your facility or any committee or department of your facility?	☐ Yes	☐ No
14.	Were any malpractice actions filed naming this health practitioner as a defendant that involved his/her period of employment at your facility?	☐ Yes	☐ No

If you answered "Yes" to any of the above questions 1-14, please explain: _____

_____

_____

15. Did this health practitioner leave your facility in good standing? ☐ Yes ☐ No

16. Would you consider rehiring this health practitioner for a position at your facility? ☐ Yes ☐ No

17. Would you recommend this health practitioner for privileges at your facility? ☐ Yes ☐ No

If you answered "No," to questions 15, 16 or 17, please explain: _____

_____

_____

18. Please supply any additional comments or information that the Committee should consider prior to determining this applicant's eligibility for licensure.

_____

_____

Please print the name and title of the Certifying Official:_____

Signature of the Certifying Official: _____

Date the form was completed: _____

Please attach a letterhead or some form of identification such as a business card for the individual supplying this information.

Please return directly to:

State Board of Medical Examiners
Physician Assistant Advisory Committee
124 Halsey Street - 6th floor
P. O. Box 45035
Newark, NJ 07101

Seal of Hospital
(If applicable)

New Jersey Office of the Attorney General
Division of Consumer Affairs
State Board of Medical Examiners
Physician Assistant Advisory Committee
124 Halsey Street, 6th Floor, P.O. Box 45035
Newark, New Jersey 07101
(973) 504-6580

Affidavit of Good Moral Character and Ethical Professional Activity

State of:_____

County of: _____

_____ of _____
Applicant's name Complete address

1. Have you ever been arrested for, formally accused of, charged with, indicted for or convicted of the commission of any crime or offense, whether state or federal, including offenses categorized as misdemeanors, high misdemeanors or felonies? ☐ Yes ☐ No

2. Have you ever been convicted of any crime or offense under any circumstances such as, but not limited to, a plea of guilty, non vult, nolo contendere, no contest, etc., or a finding by a judge or jury? ☐ Yes ☐ No

3. Have you ever been denied a license to practice as a health practitioner or the eligibility to sit for a licensing exam in this State, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

4. Has any type of disciplinary action ever been taken with respect to your license to practice as a health practitioner? ☐ Yes ☐ No

5. Have you ever been denied eligibility to participate in a medical education program in this State, any other state,the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

6. Have you ever been denied privileges or had your privileges to practice terminated or limited? ☐ Yes ☐ No

7. Have you ever been terminated from or have you ever been asked to resign from your hospital staff membership? ☐ Yes ☐ No

8. Have you ever been permitted to resign while you were under review or investigation by a health care facility or in return for not conducting an investigation? ☐ Yes ☐ No

9. Has any action ever been taken against you or is there any action pending against you now, whether for a crime or offense or any action by a regulatory agency, such as but not limited to professional licensing agencies, Medicaid, Medicare or any other governmental agency? ☐ Yes ☐ No

10. Have you ever surrendered your professional license to a regulatory agency, such as but not limited to, professional licensing agencies, or any other governmental agency? ☐ Yes ☐ No

11. Have you ever had action taken against your state or federal Controlled Dangerous Substances registrations? ☐ N/A ☐ Yes ☐ No

If you answered "Yes" to any of the above questions 1-11, you must explain in detail, and if it applies, submit a copy of the official complaint containing a full list of the charges and a copy of the final disposition papers.

12. Have you ever been the defendant in a medical malpractice suit? ☐ Yes ☐ No

a. Have you ever been denied malpractice insurance coverage? ☐ Yes ☐ No

b. Have you been assessed an individual surcharge based upon your specific claims history by any malpractice carrier? ☐ Yes ☐ No

c. Has limitation ever been required? ☐ Yes ☐ No

d. Have you ever been required to have office monitoring? ☐ Yes ☐ No

---

If you have answered "Yes" to question 12 on the affidavit, the following documentation is required:

A. A description of the clinical aspects of each incident as it would be explained to a fellow professional;

B. For each incident, you must submit a copy of the original complaint or a copy of the bill of particulars; and

C. For each closed malpractice suit, you must submit a copy of any Final Order or settlement that closed the case.

Sworn and Subscribed to me.

I have carefully read the foregoing questions and answered them completely and truthfully

Date_____ 20___

_____ _____

Signature & Seal of Notary Public Applicant's signature